Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ST LUKES REGIONAL MEDICAL CENTER
PO BOX 2777
BOISE ID 83701

Respondent Name

TPCIGA for RELIANCE NATIONAL INSURANCE

Carrier's Austin Representative Box

Box Number 50

MFDR Tracking Number

M4-08-7178-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "Fee schedule under 134.202 not applicable."

Amount in Dispute: $15,748.38

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please note that the MR-100 list the Carrier as Old Republic Insurance Company; however, the correct carrier is TPCIGA for Reliance National Insurance Company…It is the Respondent's understanding that this dispute involves inpatient services with the dates of service 1/28/08-1/31/08 for a total amount in controversy of $15,748.38 concerning Claimant [injured employee]. This is clearly a medical fee dispute. Requestor billed a total of $20,289.93 for this inpatient surgical stay. Requestor was paid $4,541.15 in accordance with DWC Rule 134.401. Requestor is requesting 100% reimbursement, which is neither fair nor reasonable, and not in accordance with the Texas Labor Code and the Rules of the Texas Department of Insurance, Division of Worker's Compensation. DWC Rule 134.401(c)(1) and 134.401 (c)(2) states that the standard per diem amount shall be used in calculating the reimbursement for acute care inpatient services. The services in dispute were considered surgical; therefore, the reimbursement shall be $1,118.00 per day. Per DWC Rule 134.401(b)(D) states that in computing a patient's length of stay, the day of admission is counted, but the day of discharge is not. Therefore, in this matter, it appears that the Claimant was admitted on 1/28/08 and discharged on 1/31/08. Therefore, his total stay was 3 (three) days. Respondent paid a total of $3,354.00 ($1,118.00 x 3) for the inpatient stay. This is consistent with DWC Rule 134.401. Additional, per DWC Rule 134.401(c)(4)(B)(i) MRIs are to be reimbursed at a fair and reasonable rate in addition to the normal per diem based reimbursement. Therefore, in accordance with this rule, Respondent paid $1,187.15 for the MRI. Respondent billed for this MRI using CPT Code 72158. The amount paid is more than the fee guideline amount… Thus, Respondent was reimbursed at a fair and reasonable rate."

The respondent also submitted an additional response dated January 19, 2011 stating, "There is no indication that this bill was reduced per an informal/voluntary contract. A review of the column 'PPO' on the EOB shows no reduction was taken. Further, the ANSI code '45' was not utilized on the EOB. Therefore, no PPO contract was utilized."

Response Submitted by: Downs-Stanford, PC, 2001 Bryan Street, Suite 4000, Dallas, TX 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 28, 2008 – January 31, 2008	Inpatient Hospital Services	$20,289.53	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.401(b)(1), (c)(1) and (c)(3) sets out the payment policies and procedures for the Division of Workers' Compensation and it's system participants to calculate the MAR for inpatient surgical services.
3. 28 Texas Administrative Code §134.1(f) sets out the procedures for fair and reasonable reimbursement.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated April 25, 2003 and May 9, 2008
   - 97 – Payment is included in the allowance for another service/procedure.
   - 42 – Charges exceed our fee schedule or maximum allowance amount.
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Under what authority is a request for medical fee dispute resolution considered?
2. Did the requestor submit the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307?
3. Was the requestor reimbursed in accordance with 28 Texas Administrative Code §134.401 and did the requestor support fair and reasonable in accordance with 28 Texas Administrative Code §134.1(f)?
4. Is the requestor entitled to additional reimbursement.

Findings

1. The requestor provided surgical services in the state of Idaho January 28, 2008 through January 31, 2008 to an injured employee with an existing Texas Workers' Compensation claim. The requestor was dissatisfied with the respondent's final action. The requestor filed for reconsideration and was denied payment after reconsideration. The requestor filed for dispute resolution under 28 Texas Administrative Code §133.307. The Division concludes that because the requestor sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules.
2. The requestor submitted the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code 133.307.
3. According to 28 Texas Administrative Code §134.401(c)(4)(B)(i) MRIs are reimbursed at a fair and reasonable rate and in accordance with 28 Texas Administrative Code §134.1(f), which states in part, that fair and reasonable reimbursement shall be consistent with the criteria of Labor Code §413.011; ensure that similar procedures provided in similar circumstances receive similar reimbursement; and be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available. The requestor did not submit documentation to support their billed charges for the MRI was fair and reasonable.
4. Review of the submitted documentation finds that the Requestor was paid in accordance with 28 Texas Administrative code §134.401(c)(1), §134.401(c)(2) and §134.401(c)(4)(B)(i); therefore, additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		May 10, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.